THE PRESENT TREND TOWARD SOCIALIZED MEDICINE

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Definitions of the term socialization of medicine are infre-
quent in the medical literature in spite of the large num-
ber of papers discussing that subject. From the contents of such
articles, it may be assumed that any entrance of government into the
field of medical practice, aside from its activities already established,
constitutes socialized medicine.

The term socialize means "to cause to be socialistic." The
term socialism is defined as "a theory of civil policy that aims at the
public collective ownership of land or capital and the collective public
management of all industries." The application of the term to medicine
is obvious.

In this discussion the former meaning of the term socializa-
tion rather than the latter definition will be adhered to for the reason
that, while strictly inaccurate, it is the common meaning of the term.
Furthermore, while this paper will present a trend towards socialization
in the loose sense, no trend towards socialization of medicine in the
strict sense of the word is believed to exist.

To avoid plunging into a detailed discussion without indicat-
ing the broad plan of attack involved in this paper, it is found necessary
to present prematurely some general conclusions, which will be substan-
tiated only after presentation of a considerable amount of detail. Cer-
tain postulates which serve as central points of discussion and which
lead to a definite conclusion by way of what it is hoped in an orderly
discussion are hereby submitted, namely:
1. Society determines the place of the physician in its organization and governs his actions. Society does not tolerate inadequate medical care.

2. The present form of medical care has grave deficiencies.

3. Public opinion has come to demand a type of medical care distinctly at variance with the present method of supplying such care; at variance with the medical attitude towards its problems.

4. Society is proceeding to supply such care as the people demand.

THE RELATIONSHIP OF SOCIETY TO MEDICAL PRACTICE

When a community finds itself supplied with a sufficient number of physicians, when the cost of medical care is low, and the majority of the members of this community possess sufficient wealth to purchase the services of a doctor, no need for medical organization will ever be felt.

The situation, however, is immediately changed as soon as the doctors are scarce or as soon as their services for one reason or another becomes unattainable to large parts of the population. In such case some kind of organization will have to be created, at least in such societies as have recognized that good general health conditions benefit the individual, that the prosperity of a commonwealth largely depends on
the health of its citizens and that the community as such is responsible for the welfare of its members.

The author of the above statement is Henry E. Sigerist. The statement is substantiated by a discussion of the relationship of medical men and the public in the Greek world of the fifth century, B.C., in ancient Rome, under the guild system of medieval times and in Europe since the middle of the nineteenth century. The same author states elsewhere, "There is one lesson that can be derived from history. It is this: That the physician's position in society is never determined by the physician himself, but by the society he is serving. We can oppose the development, we can retard it, but we will be unable to stop it."

Sir Arthur Newsholme expresses this view in the form of postulates as follows:

1. Neither public opinion nor medical conscience can tolerate the continuance of neglected sickness.

2. Medical care in its widest sense must be made available for all as an important element in securing maximum efficiency and happiness in a civilized community.

Statesmen from Disraeli to Roosevelt have expressed the thought that the care of the public health is a primary responsibility of government. Blackstone interpreted the legal aspect when he said, "The right to the enjoyment of health is a subdivision of the right of personal
liberty, one of the absolute rights of persons."

**THE PRESENT TYPE OF MEDICAL PRACTICE; ITS ADEQUACY OR INADEQUACY.**

Early in his second administration President Theodore Roosevelt appointed a committee of one hundred to investigate the problem of the conservation of the vital resources. The report submitted by Irving Fisher of Yale stated that three billions of dollars were lost yearly because medical knowledge was not made available to the people.

The Committee on the Cost of Medical Care in regard to the question of economic loss due to sickness and preventable deaths presents the following data:

At any specified time 2% of people are incapacitated for work due to sickness, in the case of children are incapacitated from attending school because of sickness. A very conservative estimate of the economic loss due to this amounts to $250,000,000 to $500,000,000 per year.

Larger losses result from sickness which terminates in premature mortality. Capital loss from preventable infant mortality equals $750,000,000 per year. Capital loss from preventable deaths between the ages of 25 and 29 years amounts to $750,000,000 per year. Capital loss from preventable deaths at all ages equals six
billion of dollars per year.

The Committee on the Costs of Medical Care has determined morbidity and mortality rates for an average standard population of 100,000, has analyzed the medical care at present rendered to such a group, and has compared this service with an estimated minimum service necessary to provide the fundamentals of good medical care to such a group. The estimate has been prepared by a committee of medical experts. The results are presented graphically. They require no explanation. They constitute a striking indictment of present medical care.
Family income in thousands of dollars.

Family income in dollars
In reviewing these graphs it should be borne in mind that 90% of the population group falls in the class with incomes below $5,000.00.

Incriminations of medical care are frequently encountered. Van Etten states: "Every man, woman, and child loses one week per year through sickness, much of which is preventable. 12,000 infants die each year, 30,000 persons of the age group 25-29 die from entirely preventable causes."

William Trufant Foster, one of the most outspoken critics of medical service expresses its deficiencies as follows: "Under the prevailing form of medical service, private individual practice, more than 50,000,000 persons either do not receive the care which they need and with which they could readily be provided or they are heavily burdened by its costs."

The President of the American College of Surgeons in his inaugural address agrees that within the past few years it has become increasingly apparent that competent medical and surgical service is not obtained by all classes of the population.

Having examined the inadequacies of present medical care, one may logically ask, "Why the inadequacy?" The Committee on the Costs of Medical Care has stated that medical and hospital facilities are adequate in the nation as a whole. They are subject to only two criticisms, namely -

1. That they are improperly distributed, resulting
in local inadequacies, and

2. That there is no consumer guidance in medical care.

Furthermore, the National income as a whole is adequate to pay for the use of these medical facilities, but costs of sickness are unpredictable and in many instances large bills must be met suddenly. As illustrative of this the following data is submitted.

If the total medical bill for families with incomes of less than $1,200 were equally distributed each would be charged $49.00, but the uneven incidence of sickness produces this result: One-third of the costs in this group are borne by 80% of the families. The second one-third is borne by 17% of families and the third equal division of total costs is borne by 3.5% of families. The latter group receives bills equalling 53% of their average annual income.

The same situation holds in the higher income groups to a lesser degree. In the class with family income totalling $3,000 to $5,000, one-half the costs are borne by 86% of families and one-half the costs by 14% of families.

The cause of insufficient medical service, therefore, appears to be economic in nature.

THE ATTITUDE OF THE PUBLIC TOWARD THE MEDICAL PROFESSION.

Sociologists today are rather impressed with the importance of attitudes regarding them as basic realities in social situations. The
existence of a widespread attitude is certainly something which cannot be ignored, whatever one may think of its justice or soundness. It is important then to examine the attitude of the public to the medical profession, toward medical service.

As the product of our early isolated manner of living and individualistic philosophy medical practice was viewed almost entirely from an individual viewpoint.

In recent years this attitude has been changing as a result of experience. Social factors stand out clearly as contributing to this change. They are public health work, particularly health work in the schools, military service and veterans' medical care, industrial health service. Let us examine each of these developments in some detail.

The United States Public Health Service has grown from an organization formed in 1798 to care for American seamen and including a very limited personnel, to an organization employing more than 8,000 persons and expending some $10,500,000 annually, having a multiplicity of functions. Today this organization furnishes medical care to seamen, prevents introduction of disease from foreign countries as well as interstate spread of disease, carries on supervision of biological products and conducts medical research, disseminates public health information and cooperates with state and local public health departments.

With this organization has grown local public health services, conducting local health projects. These organizations have focussed
attention on infant and child welfare, on disease prevention and sanitation. In two decades infant mortality has been cut in half, deaths from tuberculosis have gone down 60% and some diseases such as small pox, diphtheria and typhoid are in many communities a rarity. During this period the life span has increased by nine years. All of these achievements have come through public education and through making available, in one way or another, better medical practice to large numbers of people. This cannot be without effect on public consciousness. Health work in the schools began with employment of physicians to control communicable diseases. Since the latter part of the nineteenth century the scope of medical inspection has extended to include physical examination for defects which might hinder the educational progress of children, follow-up work for correction of defects, systematic communicable disease immunization and in many cases nutrition work involving actual feeding of undernourished children. As a result there have grown up children accustomed to a reasonably adequate and free health service.

In 1917 and 1918 a great many persons entered the military service. Profiting by experience in the past modern military leaders with the aid of medical men have made their armies an example and an inspiration for our public health authorities in times of peace. The result was that millions of young men had the experience of being served by a very effective health service. Furthermore, for veterans this experience was continued after the war. At the end of the war the United States Public Health Service and after 1922 the Veterans Bureau found itself in possession of 57 hospitals with a capacity of 17,500 beds and a
The injured World War veterans having been cared for, these hospitals began to empty. But in 1924 Congress enacted an amendment to the World War Veterans Act (which had previously provided for care of service disabilities) which stipulated that veterans with certain types of disabilities not of service origin would be admitted to Veterans' Hospitals as long as beds were available. In 1926 there was enacted a further amendment providing that veterans of all wars be admitted to all hospitals free of charge for any disability however incurred which required hospitalization. In 1930 70% of admissions were for disabilities not of service origin. In 1931 the capacity of Veterans' hospitals was 25,930 beds in 53 hospitals.

In industry there has been a distinct trend towards an increasingly complete medical service. In the decade between the years 1910 and 1920 the manufacturers were confronted with the acts of state legislators saddling him with the responsibility for industrial injuries and in some states for occupational diseases. The manufacturer, facing the problem from an economic standpoint very early made two important discoveries. The first, that accident prevention is cheaper than accident treatment and compensation. The second that indiscriminate handling of real or alleged injuries by physicians chosen at random eventuated in a total cost nearly double that required for all services carried out under a unified service by a thoroughly competent physician chosen with full consideration of the patient's interest.
Confronted with this situation there was created the plant medical department. Once in the employ of industry, the medical man found many other things to do.

The National Industrial Conference Board in its last report lists the objectives of the medical department in the following inclusive terms:

1. To place the individual in work for which he is best fitted.

2. To procure and maintain fitness for work.

3. To educate the workers in personal hygiene and accident prevention.

4. To reduce loss of time, absent periods and short work span.

In attaining the above objectives medical departments in industry are engaged in the following activities:

1. Physical examination of:

   a. Applicants for work
   b. Absentees from work on their return to work
   c. Employees being transferred from one department to another.
   d. Employees to be promoted.
   e. Those engaged in occupations hazardous to their health or to the safety of others.
   f. Those with defects that should be followed up.
   g. Older workers.
   h. All workers in a general plan of health promotion.
2. Diagnosis and treatment of occupational injuries.
3. Diagnosis and occasionally treatment of surgical conditions not resultant from working conditions.
4. Diagnosis and treatment of minor illnesses, usually only so long as the patient can visit the plant dispensary.
5. Assistance through advice on obtaining treatment outside the plant for serious conditions.
6. Education of workers in health habits, personal hygiene and safety practices.
7. Supervision of working conditions that affect health.
8. Research

Of the 1,808 companies covered by the 1930 survey of the National Industrial Conference Board, 53% make an initial examination of employees, 20% make subsequent examinations. Such services as have been enumerated thus far constitute a fairly extensive gratuitous health service. In certain instances industry has gone still further in providing medical services for its employees.

If it be granted that maximum efficiency in industry depends upon a working force which enjoys a maximum degree of physical and mental health, it is clear that the employer is vitally concerned with the general medical care of employees. If the private facilities are adequate, well and good. If not the employer may very well consider whether a
further extension of industrial health service may not bring returns 13 commensurate with the cost involved.

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According to Pierce Williams, in the year 1930 about 540,000 gainfully employed persons in the mining and lumbering industries throughout the country, in consideration of fixed periodic deductions from wages, were eligible for medical care including industrial and nonindustrial illnesses. Similar services were provided for one-third of the employees of Class I railroads in the United States, by membership in employee hospital associations.

The final extension of industrial medical service cares for the employee and his family as well on the grounds that an employee is not an isolated unit, but a member of a family, affected by family illness in such a way that his efficiency may be impaired.


The Endicott-Johnson Company provides complete care for 15,000 15 employees and their families. It is of good quality.

Since 1910 the Homestake Mining Company has provided complete care for 5,332 employees and dependents on a periodic payment basis.

At Roanoke Rapids, North Carolina, five industrial plants have combined to furnish medical care for employees and dependents and for the
surrounding community. Their clientele numbers 4,919 persons.

In summary we may say that the extent of industrial medical care is surprisingly great. That such care is quick, effective, easily available and cheap.

After the foregoing detailed considerations of the experience of large groups of people in infant and child care, in school, in the army, as veterans of wars or as employees of large industries, it appears that we have developed an organized effective medical and health service gratuitously given to these members of society. People will not permanently compartmentize their thinking. The attitude of these groups toward medical service will be reflected in the attitude of society as a whole toward medical service.

How definitely crystallized this attitude has become it is difficult to say, but it is clearly pointing in the direction of regarding health and adequate medical service as a social necessity and perhaps it is safe to go so far as to say, as a social right.

This attitude is expressed by other writers. Rexwald Brown states: "New currents of thought are racing through civilization, more is being demanded of medicine than a consideration only of the needs of the sick individual. Society becomes insistent that health be preserved, that medical knowledge be made available to the needs of all."

Glenn Frank, President of the University of Wisconsin, in his address to the State Medical Society in 1927, stated that unless medicine
developed the statecraft within its own ranks necessary to solve the economic problems of medicine, politicians will solve those problems for it.

The chairman of the Minority Group of the Committee of the Costs of Medical Care reports that a tide of public opinion inimical to the medical profession is rising which is already a distinct menace. Yet "if the abolition of private practice is the only practical method whereby the large percentage of the neglected can be provided for, we will have to swallow the socialism," so states a member of the ministry.

At this point we may well ask, what is the attitude of the medical profession regarding reorganization of medical service? The American Medical Association has remained consistently conservative. It upholds the right of the medical profession to say how medicine shall be practiced. It consistently opposes sickness insurance under government control, has supported individual practice as against the majority group of the Committee on the Costs of Medical Care, recommending group practice and periodic payment. The latest statement of the Board of Delegates "reaffirms encouragement to local societies to establish plans for the provision of adequate medical service for all people adjusted to present economic conditions by voluntary budgeting to meet the costs of sickness."

A minority of the medical profession approach the problem with a different viewpoint, but the opinion of the great mass of medical men remains conservative. It is often stated that the doctor is interest-
ed in one patient, mass figures mean nothing to him. He is conservatively minded. He must retain the good will of his fellows and must remain a member of the herd. Finally, physicians have no business training.

A commission organized by the Association of American Medical Colleges to study the principles involved in medical education and licensure recognizes the social changes that have occurred and the new demands being made upon the medical profession. It urges training of physicians in sociology and economics in order to fit them for the responsibility of medical care and to effect a wider application of medical knowledge.

**SOCIETY'S SOLUTION OF THE PROBLEM MEDICAL CARE**

Having presented the views that society determines the economics of medical practice and that it tolerates no gross deficiencies, that present medical practice is subject to grave criticism and that society is aroused to the necessity of a more adequate type of medical service, we may examine the specific nature of the trend towards socialized medicine. What is society doing about it? In so far as can be determined at present, the trend is towards sickness insurance.

Sickness insurance is one form of social insurance. Social insurance is insurance against poverty. The struggle against poverty under industrialism takes two forms. One seeks to reorganize the whole social set-up; the other accepts insufficiencies as inevitable and seeks to palliate them. The latter group is responsible for humanitarian legislation and social insurance.
Sociologists have long thought and taught that in the present state of society poverty could be relieved by insurance against sickness, accidents, invalidity, maternal disability, old age and unemployment. The acuteness and strain of the problem of poverty in all forms was felt much earlier in Europe than in the United States, and lay in back of Bismarck's introduction of sickness insurance into Germany in 1883. This was followed in a few years by other countries on the continent, in 1911 by England, since the War by France, Italy and Russia. Now 100,000,000 people come under this type of insurance.

In a recent message to Congress President Roosevelt said, "Closely related to the broad problem of livelihood is that of security against the major hazards of life. Here also a comprehensive survey of what has been attempted or accomplished in other countries proves to me that the time has come for action by the national government. I shall send you in a few days definite recommendations on these subjects. These recommendations will cover the broad subjects of unemployment and old age insurance, benefits for children, for mothers, for the handicapped, for maternity cases and for other aspects of dependency and illness where a beginning can be made." This is reported in the Journal of the American Medical Association.

The President's Committee on Economic Security composed of cabinet members and government officials is studying actively the subject of sickness insurance. They have already recommended as a first step for meeting the problem of sickness in families with low income wide-
spread public health service. The second major step they propose is sickness insurance. Not as yet ready to make specific recommendations the support of the medical and dental professions as well as hospital management representation has been consulted.

The committee of the medical profession appointed by this group is composed of eleven medical men and four technical advisers. Of the former group nine are avowed proponents of sickness insurance or signers of the majority report of the Committee on the Costs of Medical Care. Two members support the policy of the American Medical Association. The technical staff is composed of men active in preparation of the reports of the Committee on the Costs of Medical Care.

The President's Committee on Economic Security has submitted recently a report indicating the main lines along which their study is proceeding. They state:

1. The fundamentals of health insurance are —

   a. The provision of adequate health and medical services to the insured population and their families.

   b. The development of a system whereby the people are enabled to budget the cost of wage loss and of medical cost.

   c. The assurance of reasonably adequate remuneration to the medical practitioner and medical institutions.

   d. The development under professional auspices of new incentives for improvement in the quality of medical services.
2. In the administration of such services the medical profession should be accorded responsibility for the control of professional personnel and procedures, and for maintenance and improvement of the quality of service; the practitioner should have broad freedom to engage in insurance practice, to accept or reject patients, and to choose to procedure of remuneration for their services; insured persons should have freedom to choose their physician and institution and the insurance plan shall recognize the continuance of the private practice of medicine and the allied professions.

3. Commercial and intermediary agencies between the insured population and the profession serving them should be excluded.

4. Insurance benefits must be considered in two broad classes:
   A. Cash payments in partial replacement of wage loss due to sickness and for maternity cases, and B. Health and Medical Services.

5. The administration of cash payments should be designed along the same general lines as for unemployment insurance and so far as may be practical should be linked with the administration of unemployment benefits.

6. Administration of health and medical services should be designed on a state-wide basis under a Federal law of permissive character. The administrative provisions should be adapted to agricultural and sparsely settled areas as well as to industrial sections through the use of alternative procedures in raising the funds and furnishing the services.
7. The costs of cash payments to serve in partial replacement of wage losses are estimated as from 1-1.5% of the payroll.

8. The cost of health and medical service under health insurance for the employed population with family earnings up to $3,000. per year is not primarily a problem of finding new funds, but of budgeting present expenditures so that each family carries an average risk rather than an uncertain risk. The population covered is accustomed to spend in the average about 4.5% of its income for medical care.

9. Existing health and medical services provided by public funds for certain diseases or for the entire population should be correlated with the services required under a contributing plan of health insurance.

10. Health and medical services for persons without incomes now mainly provided by public funds could be absorbed into a contributory insurance system, through the payment by relief or other public agencies of adjusted contributions for these classes.

11. The role of the Federal government is principally:

   a. To establish minimum standards of health insurance practice.

   b. To provide subsidies, grants, or other financial aids to states which undertake the development of health insurance systems which meet the Federal standards.


5. Committee on the Costs of Medical Care. Publication No. 27, page 12.
   5A. Publication No. 22,
   5B. Publication No. 27, page 74.


15. Medical Care for 15,000 Workers and Their Families, Publication No. 5. Committee on Costs of Medical Care.


Approved by

[Signature]
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Date

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